WHAT TELEMEDICINE COULD MEAN FOR FUTURE ABORTION CARE IN THE UNITED STATES

by

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A thesis submitted to Johns Hopkins University in conformity with the requirements for the degree of Master of Bioethics.

Baltimore, Maryland

April 2019

Abstract

Women in the United States possess a right to abortion care; however, this right is under threat. Abortion clinics are closing at alarming rates as the right to abortion care is increasingly undermined by restrictive legislative policies and reduced access across the country. The use of telemedicine to provide 'care from a distance' has become widely adopted in the broader healthcare setting. Telemedicine may offer significant advantages in the context of medication abortion; and the delivery of medication abortion services through telemedicine platforms (teleabortion) has, indeed, been the natural development in response to shrinking abortion access. Not only might teleabortion promote abortion access to all women across the United States, it may also offer other significant advantages including the promotion of individual privacy, reduced care costs, and the minimization of stigma associated with abortion care. While it is clear that teleabortion is a novel strategy to a growing problem, we cannot affirm teleabortion to be the resolution to diminishing abortion rights in the United States. Women should be able to receive the basic healthcare they need, but current trends in abortion care suggest that we may be moving farther away from this ideal. Rather than address the morality of abortion, the purpose of this thesis is to explore the place of teleabortion in the future of abortion care in the United States and the ways in which teleabortion may change the landscape of the right to abortion care, as well as determine whether teleabortion is a platform we ought to promote. In it, I will argue that teleabortion only offers a temporary remedy to a deeply-rooted problem of injustice that demands ethical action.

Primary Reader: Travis Rieder, Ph.D.

Secondary Reader: Anne Barnhill, Ph.D.

Acknowledgements

My sincerest gratitude goes out to the following individuals, all of whom made significant contributions to the content of this thesis: Travis Rieder, Ph.D., Anne Barnhill, Ph.D., Vivian Altiery De Jesus, Cami Docchio, Margot Kelly-Hedrick, Christen Paradissis, and Hunter Jackson Smith, M.D., M.P.H.

I would like to specially thank my incredible family for their unwavering support and patience when I needed advice, sympathies, encouragement, or just a sounding board.

Finally, I would like to thank my partner Nick, whose unconditional love and encouragement always inspired me to keep going. Thank you for being my cheerleader, confidant, and caretaker when I needed it most.

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1 Introduction

The right to an abortion in the United States (US) is guaranteed by the decision in *Roe v.* Wade, which tied access to abortion to the Constitutional right to privacy. However, this right has fallen under increasing threat. Historically, the right to an abortion has been leveraged as a partisan talking-point used to parse social groups by moral belief. Today, the right to an abortion is seriously threatened by lack of access as the morality of abortion care continues to be debated. While the abortion debate remains unresolved, the purpose of this thesis is not intended to contribute to the healthy literature on the permissibility of abortion. While receipt of an abortion remains a constitutional right in the US, we have seen the recent expansion of a novel strategy to enhance access to abortion care across the country. The provision of medication abortion services, which employs the platform of telemedicine (hereinafter referred to as 'teleabortion') has gained popularity as a potential strategy to boost abortion access. Although women maintain the right to an abortion at the Federal level, abortion care is largely regulated at the state level, which has led to inconsistencies in access and care across the country. Teleabortion is capable of expanding abortion access across the US and may potentially offer a supplement to current in-clinic abortion services, which have been increasingly restricted.

While there seems to be a growing demand for teleabortion services, the ethical implications and justifiability of this strategy have not yet been examined. Given that the right to an abortion is still upheld in the US, it is unclear whether we ought to support the use of teleabortion. Ultimately, teleabortion addresses growing problems with abortion care in the US, but its enthusiastic adoption against the backdrop of rising abortion restrictions may have undesirable consequences for women's health and reproductive liberties. The purpose of this thesis is to explore the place of

teleabortion in the future of abortion care in the US and the ways in which teleabortion may change the landscape of the right women have to an abortion, as well as determine whether teleabortion is a platform we ought to promote.

1.1 Abortion in the United States

Since the 1973 United States Supreme Court ruling of *Roe v. Wade*, the right to obtain an abortion up to 'viability'[1] in the US has been protected by Constitutional Law ("Roe V. Wade: The Constitutional Right to Access Safe, Legal Abortion"). Since *Roe v. Wade*, abortion has remained an important issue about which little national or political or social compromise has been achieved. Although the legal precedent of *Roe v. Wade* guaranteed that women could no longer be criminalized or denied access to an abortion in the US, opposition has continued to debate the legal and moral acceptability of abortion. Such opposition and rivaling views have led to countless stalemates about the origins of life, a woman's right to choose, and the role government should play in guaranteeing access to reproductive choice. While the moral queries raised by abortion remain unsolved, access to abortion has been settled law for nearly four decades. However, recent political changes have led many to worry about the protection of abortion rights in the US.

While the right to an abortion is guaranteed at the federal level, states have the authority to enact their own state-wide stipulations of this law. This authority to alter access to abortion, either for minimization or expansion, has been left up to the discretion of state legislatures and their representatives and populace to decide. Although some states have sought to use this sovereignty

[1] 'Viability' as defined in *Roe v. Wade* (1973) refers to the ability of the fetus to "potentially able to live outside the mother's womb, albeit with artificial aid" (Wood and Hawkins).

to expand abortion rights, the majority of states have sought to limit abortion rights through the implementation of restrictive abortion laws and complicated legal requirements, or physical limitations to access. In 2013, 41 states had enacted various abortion restrictions intended to prevent women from accessing and obtaining an abortion, including 24-72 hour mandatory waiting periods ("For a Safe Abortion"), fetal heartbeat bans (Chokshi), gestational limits including second trimester abortion bans, required counseling and/or ultrasound, and many others ("Abortion Restrictions in States"). As of January 2019, the number of states that have gestational limits has risen to 43 ("States with Gestational Limits for Abortion"; "An Overview of Abortion Laws"). The legislative authority that has been preserved at the state-level has led to an incredibly diverse legal topography of abortion rights in the US. Some states, including Texas and Louisiana, have adopted highly restrictive abortion laws in an attempt to limit women's access and use of abortion, including a law that was introduced in Texas, which would "criminalize abortion without exception" and make it possible to charge a woman with the death penalty for having an abortion (Stanley-Becker)[2]. Notably, there are six states[3] that have only one abortion clinic to serve their entire state (Madsen et al.). In addition, the number of abortion clinics across the country have steadily declined in the last several years. In 2018 alone, 40 abortion clinics closed, leaving behind a total of 679 surgical and/or chemical facilities to serve the entire US population (Madsen et al.; Sullenger). Conversely, other states including New York and Oregon have enacted more progressive abortion laws, which extend the initial grounds of *Roe v. Wade* far beyond what is laid out in the Constitution (Miller).

[2] In the case of Roe v. Wade, 410 U.S. 113 (1973) the United States Supreme Court ruled 7-2 that a right to privacy under the Due Process Clause of the 14th Amendment of the US Constitution extended to a woman's decision to have an abortion. However, this right must be balanced against state's interests in regulating abortions for the protection of women's health and the potentiality of human life ("Roe V. Wade, 410 U.S. 113").

[3] Currently, six states have only one abortion care provider to serve the entire state. These states are: Kentucky, Mississippi, North Dakota, West Virginia, Missouri, and South Dakota (Madsen et al.).

What does the abortion landscape look like in the US?

Abortion is one of the safest medical procedures available in the US ("Safety of Abortion"; "Induced Abortion in the United States"; "Medication Abortion" (Guttmacher Institute); Kodjak; "How Safe Is an in-Clinic Abortion?"; "How Safe Is the Abortion Pill?"). Since legalization in 1973, more than 61 million women in the US have had an abortion (Clock.org). The need for abortion services transcend all races, ethnicities, economic backgrounds, religious affiliations, ages, and sexual orientations (Madsen et al.). The largest number of abortion services are provided through independent clinics, which provide more than half of all abortion care in the US, while the second highest provider of abortion services provider is Planned Parenthood (Madsen et al.). As aforementioned, individual states have implemented legal restrictions on abortion services, which have affected abortion providers, and women seeking or in need of an abortion. As the landscape of abortion rights has changed throughout the decades, US abortion rates have reached a historic low (Jones and Jerman). While this may be an encouraging sign for many, it is unclear whether such historically low rates of abortion are reflective of improved access to reproductive health services and family planning, or alternatively, are reflective of tightening restrictions and diminishing access to abortion care for women across the US (Beckman; "Induced Abortion in the United States").

In addition to state-wide customization, abortion care in the US has experienced political and social backlash, which could threaten the right to an abortion. Although abortion in the US has remained federal law, the current US political backdrop has rendered the future of abortion laws and access unpredictable. For example, the Trump Administration implemented legislation that could further limit the legal standing of *Roe v. Wade*, and even prohibit specific abortion services or conditions

under which a woman could receive an abortion (Reuters). Additionally, with a conservative majority on the US Supreme Court, concern has been raised over the legacy of *Roe v. Wade* as 'settled law'. Threats to abortion access at the federal and state-level have contributed to the uncertainty of future of abortion care in the US. One indication of the future of abortion access in the US can be seen through the number of existing abortion clinics and providers. As it stands, the closure of abortion clinics across the US may reveal where the future of abortion is going (Madsen et al.).

1.2 Telemedicine

As abortion rights in the US have come under fire, the provision of certain forms of abortion services through telemedicine offers a novel way to supplement existing abortion access in the US. Telemedicine is broadly defined as the use of telecommunication and information technology to provide healthcare remotely (Kaplan). According to the American Telemedicine Association (ATA), telemedicine is the expected evolution of healthcare in the digital world. As technology quickly advances, phone and video-based transactions have become customary in hospital and healthcare settings across the country. The applications of telemedicine are broad; providers can video-conference with patients for consultations, monitor vital signs remotely, or write prescriptions ("Telehealth Basics").

Advantages of Telemedicine

Telemedicine offers several advantages to both providers and patients. Firstly, telemedicine can provide expert 'care at a distance', enabling greater mobility in the provision of healthcare. Through this platform, patients who may be hundreds of miles away from a hospital or clinic can

interact with providers. To this end, telemedicine can offer huge benefits to patients living in remote areas by providing access to expert care and support (Kaplan). Secondly, telemedicine can offer both patients and providers a level of convenience that is often unachievable in a traditional medical setting. For routine or acute care for ailments such as common colds, bacterial infections, or rashes, telemedicine can be an incredibly convenient and time-saving platform through which to interact with patients. Providers are able to 'virtually' diagnose and prescribe patients medication for their ailments at little expense to either party's time or resources ("Telehealth: The Balance between Access and Ethics"; Rehm). The convenience of telemedicine can also offer patients a level of comfortability and privacy, by enabling them to remain in their own home while receiving quality care (Kaplan). Telemedicine can further be advantageous for reducing healthcare costs, as patients may pay less in cost for better service. A 2014 study assessing the cost-effectiveness of telemedicine found that the average cost of a "virtual visit" via telemedicine was between $40-$50, while the average cost of an in-person care visit could be as much as $176 (Rehm; Yamamoto). It is clear that the cost-savings of telemedicine are highly advantageous to patients, providers, insurers, as well as the broader healthcare system. Furthermore, this platform may free up healthcare resources and time for patients who present with more severe ailments and may require more expensive and intensive in-person care (Kaplan).

Disadvantages of Telemedicine

As telemedicine has become more widespread in the US, some states have begun to enact legislation to regulate telemedicine and allow telemedicine encounters to be billed through private insurers. In 2016, the American Medical Association (AMA) created new guidelines for the ethical practice in telemedicine in the AMA Code of Medical Ethics. These guidelines recognized that the

“physicians’ fundamental ethical responsibilities do not change” as a result of telemedicine, but the “continuum of possible patient-physician interactions in [telemedicine] give rise to different levels of accountability for physicians” (“Ethical Practice in Telemedicine”). As illustrated by the language of the AMA Code of Medical Ethics, telemedicine must be borne out carefully and cautiously. In contrast to traditional patient interactions in hospitals or clinics, telemedicine is a “new model of care” in which the provider’s role may play out very differently (Kaplan). To this end, telemedicine raises several challenges, which warrant greater legal and ethical attention.

The primary criticism of telemedicine is the potential impact it has on the physician-patient relationship. An important component of any traditional healthcare interaction is the establishment of trust between patient and provider. This established trust allows providers to understand their patient’s values as well as the broader social and economic forces that affect their patient’s daily lives. This information enables providers to make inferences about their patient’s care and the best course of action for the health of that patient (Kaplan). The provision of care is an incredibly intimate experience and an interaction in which relationships matter. For this reason the rise of telemedicine has been met with strong pushback. One such example was the 2015 case, *Teladoc, Inc. v. Texas Medical Board* ("Telehealth: The Balance between Access and Ethics"). Teladoc Inc. hired physicians in Texas to provide prescriptions to patients after a phone-consultation; however, the Texas Medical Board felt that a phone-consultation was not sufficient to establish a connection between patient and provider, nor was it adequate for the release of a prescription. In their lawsuit, the Texas Medical Board claimed that physicians working with Teladoc Inc. failed to “establish a proper professional relationship with [their] patient” (Nuzback). In response to burgeoning concern over telemedicine, the American College of Physicians (ACP) issued recommendations

for the use of telemedicine, specifically in the context of primary care, stating that “a valid patient-physician relationship must be established for a professionally responsible telemedicine service to take place” (Daniel et al.). While this statement highlights the importance of the physician-patient relationship, the ACP also offered strategies to establish a physician-patient relationship through real time video/audio technology ("Telehealth: The Balance between Access and Ethics"; Daniel et al.).

One of the greatest limitations of telemedicine is the absence of certain sensory methods which are often necessary for patient diagnosis and clinical interpretation. There are many instances in which a patient’s examination cannot be done virtually, as some diagnoses require tactility, observation, or real-time diagnostic testing and analysis. Although telemedicine may provide substantial benefit for acute or primary care, it is largely ineffective, and even dangerous, if employed for other more serious ailments. The boundaries of clinical practice are far greater than the boundaries of telemedicine; therefore, the use of telemedicine is inappropriate for some forms of clinical care such as diagnosis of chronic diseases, broken bones, or necessary lab tests (Rehm).

Although states across the US have started to enact legislation intended to regulate telemedicine, telemedicine is a vast and rapidly evolving field that is largely unregulated. Guidelines are urgently needed to govern the protection and storage of patient data amassed through telemedicine services (Kaplan). Telemedicine platforms including apps, social networking healthcare sites, and other private platforms are not subject to legislative privacy and cybersecurity protections, which can lead to concerns over patient privacy and protection (Kaplan; Rehm). Concerns of data breaches and cyber security threats are a growing concern as we rely on technological platforms to store

and protect private patient information. Similar concerns exist over the use of electronic medical records; however, telemedicine adds an additional vulnerability in the broader healthcare system through which confidential and identifiable data can be compromised.

Lastly, the virtual nature of telemedicine raises issues surrounding patient compliance and responsibility that may not arise in a traditional clinical setting ("Telehealth: The Balance between Access and Ethics"). Because telemedicine often involves the virtual interaction of a patient and physician who do not have an established or trusting relationship, this can result in improper assumptions about the patient's understanding, cooperation, and compliance at the behest of the provider. Even in an in-person setting it can be hard to gauge a patient's understanding or comprehension during a clinical interaction; however, providers can rely on non-verbal cues to fill in any gaps—when the personal interface is removed, this can be nearly impossible. In a telemedical interaction, providers may misinterpret patients' complaints or requests, or patients may withhold information or feel uncomfortable asking for clarification. This could lead to misinformed assumptions about both the provider's responsibility and the patient's responsibility in their care.

As the application of telemedicine grows, there has been debate about its acceptability. Telemedicine offers significant benefits to individuals seeking acute care, who are unable to access in-clinic services, but the use of telemedicine may come at some cost to both the individual and the broader health care system. Upon evaluation, the advantages of telemedicine likely outweigh the drawbacks of telemedicine and healthcare systems and providers have enthusiastically begun to incorporate telemedicine in their regular services. Overall, the growing popularity of

telemedicine has filled a gap in the current delivery of healthcare in the US, which has resulted in an increasing adoption of telemedicine in the healthcare setting ("Telehealth Basics") and broader healthcare coverage across the US.

1.3 Teleabortion

As the use of telemedicine becomes more ubiquitous, it has been applied in various care contexts. One of these contexts is the provision of medication abortion services to women in the US. This service, which I describe as 'teleabortion' involves the remote delivery of medication abortion services through an online provider. Briefly, women who are fewer than nine weeks pregnant are prescribed mifepristone (common name: Mifeprex) and misoprostol (common name: Cytotec) (abortion pills) to induce an abortion during a video-consult with a licensed physician. The abortion pills are then mailed to the woman's home where she can self-administer the medication as prescribed to induce her own abortion. Women on Web, an organization founded in 2005, has pioneered the field of teleabortion, supplying more than 200,000 women across 140 countries with online teleabortion services (Grant). Prior to 2018, Women on Web did not offer teleabortion services to women in the US. Aid Access, a US-based website for Women on Web was created in response to a growing demand for teleabortion services and remote access to medication abortion pills ("For a Safe Abortion"). Through Aid Access, women in the US can obtain abortion pills through the process described above. To ease the abortion process or address any confusion about medication abortions, Aid Access provides a detailed instructional video on "how to use abortion pills" and offers a "Q&A" section as well as a contact email where women can submit any questions or concerns they may have about their medication abortion.

Advantages of Teleabortion

Many of the advantages provided by telemedicine hold for teleabortion; however, the uniqueness of the services provided by teleabortion can be further emphasized, as they apply to women's health and reproductive rights. In several pilot studies conducted in the US, teleabortion was demonstrated to be safe and effective (Beckman; Chong et al.). First and foremost, teleabortion was designed to increase abortion access, and has largely been popularized as access to abortion care in the US has changed. Due to increased clinic closures (Madsen et al.) and barriers to abortion care, more women have turned to teleabortion as a feasible alternative to in-clinic abortions (Beckman; Biggs et al.; Chong et al.; Norman and Dickens; Wainwright et al.). Teleabortion has provided abortion access to women who "cannot otherwise access an abortion" ("For a Safe Abortion"). At its most simplistic level, teleabortion offers both women seeking an abortion, and abortion providers a layer of convenience that is often lacking in traditional in-clinic abortion care settings (Biggs et al.; Wainwright et al.). As aforementioned, many states have implemented various restrictions on abortion ("Abortion Restrictions in States"). Through teleabortion, women can access abortion services more quickly and potentially earlier in their pregnancy (Beckman), as well as avoid some of the challenges associated with clinical abortions, such as transportation, childcare, time of work, and lost wages. In addition, teleabortion can be significantly cost-saving ("For a Safe Abortion"; Wainwright et al.). While the cost of an in-clinic abortion can range between $350-950 (Planned Parenthood), the cost of a medication abortion through Aid Access is $95, but is charged on a sliding scale based on the woman's ability to pay ("For a Safe Abortion").

Part of the large appeal of teleabortion has been the preservation of women's privacy. As alluded to above, abortion is a highly stigmatizing procedure that can be traumatic for women of all ages.

Women entering facilities that provide in-clinic abortion care have reported being met by groups of protestors who have touted graphic signs of deceased fetuses, pelted women entering the clinic with dismembered doll parts, or spouted verbal harassments. One woman who received an abortion even reported being diagnosed with post-traumatic stress disorder the year after her abortion (Welch). Having an abortion can already be an emotionally-heightened process without the addition of dissenting protestors. By receiving the medication needed to induce an abortion at home, women are able to avoid traveling to an abortion clinic, where they may experience stigma, emotional distress, or even harassment (Biggs et al.; Wainwright et al.). Teleabortion can be an empowering and rewarding experience for women making the choice to have an abortion as it can provide women with the tools to manage the stigma surrounding abortion (Wainwright et al.), serving as an emotional relief for many.

Although teleabortion can offer many advantages for women seeking abortion services, it is not free from drawbacks. The specific disadvantages of teleabortion are detailed in later sections of this thesis, and are used to ethically evaluate the permissibility of teleabortion in our current and future healthcare system. The remainder of this thesis will offer a richer discussion of teleabortion and the ways in which it may highlight the current state of abortion rights in the US, as well as the direction in which abortion rights may be moving.

2 The New Age of Abortion

In considering the many ways in which abortion rights in the US have come under threat, teleabortion offers a partial solution by increasing the delivery of medication abortion services to women across the US. However, even if we accept abortion as permissible, it is unclear whether

teleabortion is also ethically permissible. Although the future of abortion care may inevitably lead to teleabortion, few have considered the potential consequences of teleabortion and its impact on abortion care and services. Teleabortion may address many of the glaring issues threatening abortion rights in the US; however, teleabortion raises its own complexities, which demand careful consideration and ethical evaluation to gauge the permissibility of this platform. In the remaining sections of this thesis, I evaluate the ethical implications that teleabortion raises in order to provide some guidance regarding this technology.

2.1 Balancing the Pros and Cons of Teleabortion

As described above in section **1.3**, many of the critiques of teleabortion are concordant with telemedicine more broadly. Much of the exploratory work done in the remaining sections of this paper borrow from the broader platform of telemedicine. While abortion services are not the routine, acute care traditionally provided through telemedicine, this does not mean that standard telemedicine services cannot be adapted to provide abortion care. Telemedical platforms have been tailored to support the needs of women and provide a means to an abortion when there may be none, forming the foundation of teleabortion. The question remains, whether teleabortion raises all and only the same concerns as other forms of telemedicine, or whether it raises entirely new concerns that are distinct from telemedicine.

2.1.a. [Abortion] care at a distance

Growing health disparities in the US have highlighted the injustices in our country's healthcare system and left a wide gap in care. Like those associated with other healthcare, disparities in abortion care in the US are vast. As abortion access becomes increasingly limited, many women

are left with few options to exercise control over their reproductive health (Beckman; Biggs et al.; Chong et al.; Norman and Dickens; Wainwright et al.). Teleabortion can provide a safe alternative for women seeking abortions, and can prevent the receipt of abortions through unsafe or illicit means. In addition, teleabortion can be equity-promoting, especially in areas where abortion clinics are limited or effectively inaccessible. Using teleabortion, women within the first nine weeks of pregnancy who live in areas where abortion clinics are few and far between now have the same opportunity to access abortion care as every other woman in the country. To this end, teleabortion can ameliorate abortion care disparities in the US and provide women in all states the *same* access to medication abortion care.

Drawbacks to abortion care at a distance

The promotion of teleabortion is a simple way to increase diminishing access to abortion; however, a huge barrier to teleabortion is the legal and regulatory policies governing both telemedicine and the distribution of mifepristone. Currently, the practice of telemedicine is illegal in 18 states, meaning that teleabortion services are, similarly, illegal in 18 states ("Medication Abortion" (Kaiser Family Foundation); Herrera). In states where telemedicine is legal, other barriers exist for women seeking abortion pills. As briefly outlined above, the medications prescribed for a medication abortion are mifepristone and misoprostol. Mifepristone is classified by the FDA as requiring risk evaluation and mitigation strategies (REMS) from the drug manufacturer to ensure “the benefits of [mifepristone] outweigh its risks” ("Approved Risk Evaluation and Mitigation Strategies (Rems)"; "Mifeprex (Mifepristone) Information"; "Medication Abortion" (Kaiser Family Foundation); Herrera). As a result, mifepristone can only

be provided to a patient by a REMS-certified healthcare provider while she is at a licensed abortion care facility ("Mifeprex (Mifepristone) Information").

A major drawback to teleabortion is REMS, but this policy is difficult to justify. When used as directed, mifepristone has been determined to be safe and effective for the termination of a pregnancy up to 70 days of gestation ("Mifeprex (Mifepristone) Information"). Furthermore, abortion is identified as one of the safest medical procedures available ("Safety of Abortion"; "Induced Abortion in the United States"; "Medication Abortion" (Guttmacher Institute); Kodjak; "How Safe Is an in-Clinic Abortion?"; "How Safe Is the Abortion Pill?"). Despite substantial evidence of the safety and efficacy of abortion medication, the FDA claims that "REMS continue to be necessary to ensure the safe use of [mifepristone]" ("Mifeprex (Mifepristone) Information"). While REMS requirements are meant to serve a protective measure, there seems to be no justification for requiring them in the case of mifepristone. After all, in-home abortion is exceptionally safe (Chong et al.; Norman and Dickens); and far more dangerous medications such as anabolic steroids and benzodiazepines, which kill tens of thousands of people each year, are *not* subject to REMS.

2.1.b. More Money. More Problems

While access is often cited as the most pressing issue regarding abortion services in the US, it is not the only morally relevant reason that teleabortion has been promoted in the US. Cost-effectiveness is an important component of healthcare services and medical treatment. Much like telemedicine can provide primary clinical care at a significantly reduced cost, teleabortion can be a far more cost-effective abortion-option for women when directly compared to in-person abortion

services ("For a Safe Abortion"; Wainwright et al.). The cost of an in-clinic medication abortion in the US can range between ~$350-950 (Planned Parenthood). Likewise, a medication abortion provided via teleabortion services can range in cost between $0-300. Although teleabortion costs can be highly variable, and even comparable to the lower price point of in-clinic abortion costs in some settings (depending on the abortion provider), current data shows that the sum total of teleabortion is a less expensive option for women seeking an abortion. This comparison is particularly stark when we consider the ancillary costs associated with in-clinic abortions, including but not limited to, travel cost, lost wages, child care services, and supplementary clinic fees. The remote nature of teleabortion means that there are fewer ancillary costs associated with teleabortion services, which equates to a lower financial burden for women. And this reduction in cost can be equity-promoting; making medication abortion care affordable means that not only the privileged have access to this service and care in the US. Despite some variability, teleabortion provides a cost-effective option for women seeking an abortion, giving us a reason to promote teleabortion as an option in the US.

2.1.c. Do Not Disturb

Patient privacy is often at the core of medical practice and healthcare delivery. While privacy is an important component of telemedicine, few medical procedures are as personal as an abortion. Abortion is a moral issue for many, and facilities that provide abortion services often draw a great deal of unwanted, and often very negative, attention (Welch). Seeking abortion care and/or having an abortion can be a highly stigmatizing experience. As such, many women have sought out ways to enhance their privacy and protect their personal choices. By confining abortion services to the home teleabortion can maximize women's privacy in a variety of ways that are both choice-

promoting and privacy-protecting. Someone eligible for teleabortion services could avoid going to an abortion clinic where she risks exposing herself to her community, clinic staff, and other patients. The virtual interface of teleabortion guarantees that a woman's identity is only revealed to a single provider rather than the numerous people she may encounter at an abortion clinic. Teleabortion also enables women to manage their own experiences with the stigma surrounding abortion through the enhancement of privacy. A woman can choose who to inform of her decision to get an abortion, rather than be forced to compromise her privacy to those who may vilify her actions or judge her personal choices.

Competing privacy considerations

Teleabortion, and telemedicine more broadly, have been championed as the protectors of patient privacy. Protecting a patient's privacy is of the utmost importance for any medical procedure and often times, her privacy is still maintained at abortion facilities in accordance with patient privacy and protection laws such as HIPAA. But, teleabortion may pose new and unforeseen risks to different types of privacy that demand consideration. Most obviously, women who use teleabortion services may not be able to protect this information from the individuals they live with or whom they may share the electronic equipment and networks necessary to access teleabortion. An individual's internet search history can be easily tracked, and operating systems or search engines may give away personal information through targeted advertisements, webpage recommendations, and search histories. This issue could become far more severe or risky for minors seeking out teleabortion services, as they may be subject to parental/guardian censorship or have limited access to electronic or social media platforms needed for teleabortion. Additionally, medication packaging or labeling received through teleabortion services may not be discrete, thus, revealing

the nature of the package and service. This could create additional privacy issues for women who may not want their neighbors, mail carriers, family members, roommates, or friends to know the contents of their package. Just like any medical procedure, special precautions should be taken to keep a woman's decision to seek any form of abortion, medication abortion via teleabortion or not, confidential (Biggs et al.; Wainwright et al.). The protection of patient privacy and confidentiality should be preserved in all clinical encounters, regardless of the form of healthcare delivery.

2.1.d. The Convenience Factor

Teleabortion can relieve some of the burden placed on providers in a growing healthcare system and convenience should be optimized for several reasons. Remote services can offload some of the work of providers by cutting down on interface hours and wait times, and by providing flexibility in scheduling. Likewise, teleabortion can cut down on patient travel time, wait time, and potentially increase face-time with providers. More specifically, teleabortion is likely to be most convenient for the woman seeking the abortion, as she does not need to leave her home to receive care.

Drawbacks of convenience

Although convenience is an attractive factor of teleabortion, promoting medical services for their convenience could be dangerous to patients and lead to the delivery of inappropriate or incomprehensive care. Telemedical encounters are often advertised for their rapidity, but this means that providers may not have or take the time needed to thoroughly consult a patient and assess their individual needs. To complicate matters more, teleabortion is characterized by a virtual interaction, which can be devoid of important in-person cues that providers rely on, including body

language and non-verbal communication. Such encounters could reduce quality healthcare down to an on-demand abortion service that is more resemblant of a business model than a healthcare model. Furthermore, the prioritization of convenience may compromise the patient-provider encounter, which is often thought to be an essential component of a clinical interaction.

Teleabortion can also raise issues of autonomy and informed consent if women are seeking teleabortion services simply for its convenience. Women may not be fully informed of the services provided by teleabortion, and may not understand the relevant risks and benefits associated with the service platform. To this end, a woman may be better served by in-clinic abortion care for various medical reasons, but the convenience of teleabortion may hinder her decision. While concerns over convenience of abortion services are justified, we as a society have prioritized convenience in healthcare delivery and medication abortion services should not be treated differently than any other telemedical service. Teleabortion can relieve a significant burden placed on providers and patients and may offer a more convenient method to receiving and providing abortion care; however, this may not be a good enough reason to fully adopt and implement teleabortion.

2.1.e. Moving Medicine: From Hospital to Home

One of the defining features of telemedicine is the delivery of medical care outside of the traditional clinic setting. As telemedicine usage becomes more widespread, individuals can access medical care from the comfort of their couch. The implementation of teleabortion means that medication abortion services can now be provided remotely to women in their own home. While the provision of medical services from home can be beneficial for many reasons, it is unclear how

the shift in clinical environment changes the landscape of medical practice. If we promote the usage of teleabortion and allow medication abortions before nine weeks to become a standard at-home procedure, then abortion care could be transformed from a medical procedure to an at-home service. But, this transition could be detrimental to abortion care. To this end, the allowance of medication abortion care to become an at-home procedure can devalue the seriousness of an abortion procedure by treating it as a form of casual care that is synonymous with telemedical care, such as diagnosing a cold, or prescribing antibiotics for an ear infection. Deemphasizing the seriousness of an abortion could influence opinions surrounding the significance and necessity of abortion care in the US. Such opinions may contribute to loss of access to in-clinic abortion services and abortion clinic closures, which we know are continuing to rise. By shifting abortion care away from the clinic and into the home, fewer women may actually be able to obtain the care they need as fewer abortion services will be available or offered. If we normalize abortion care to the home, then women and women's health may inadvertently get pushed out of the public sector. Such a trend could have detrimental consequences for women, who already experience violence, repression, and misrepresentation in society and healthcare. Thus, we must proceed with caution if want to take medication abortions out of the clinic and move them into the home.

2.1.f. Stigma

The experience of stigma can be harmful in a myriad of ways, and abortion is a highly stigmatizing medical procedure. Although teleabortion provides some mitigation of abortion-associated stigma through providing the necessary means to induce an abortion at home, we would be remiss if we did not consider the ways in which women who *do not use* teleabortion services could be increasingly stigmatized if in-clinical abortions become less common. Women seeking in-clinic

abortions are already bombarded by protesters with negative actions or words. As such, if teleabortion became increasingly common, the spectacle of a woman seeking an in-clinic abortion could lead to harsher and more intensified retaliations against her. Her actions may be hyperbolized as anti-abortion activists interact with fewer women in need of in-clinic abortion care. As such, we should question whether teleabortion could actually increase the stigma associated with abortion, as it becomes a procedure that is largely done in the home and away from the public.

As the landscape of abortion care changes with the medicalization of the home, teleabortion could inadvertently increase violence against women in new, unforeseen ways, especially women who do not seek abortion care through teleabortion. That said, rather than hiding abortions away from the public view in order to prevent stigma, we must take the steps to normalize *all* abortion procedures regardless of what setting they occur in.

2.2 New Might Not Mean Better: What could teleabortion do to existing abortion clinics?

The application of teleabortion in the US is relatively new; however, some of the earliest versions of telemedicine date back to the 1950s (Vinches). While the future of teleabortion is still unclear, the history of telemedicine can lend itself to the analysis of teleabortion, and the potential consequences we may come to expect if teleabortion is not promoted in an ethically responsible way. In addition to creating risks to privacy, stigma, and traditional clinical care, among others, it is unclear the effects that teleabortion may have on existing abortion clinics.

Clinic closures are a serious concern for many and could further amplify health disparities across the US. The idea is that if more patients receive care through telemedicine, this would be harmful for clinics' business (e.g. for an urgent care facility in a rural area). Clinics that do not perform

well, or that cannot sustain their operating costs might go out of business, which would then decrease access to care for individuals who do not use telemedicine or who really need the clinic. Similarly, the same argument can also be made for teleabortion. We have data to show that abortion clinics are closing at an alarming rate (Madsen et al.) and it is likely that this trend will continue, especially if more women utilize teleabortion services in place of in-clinic abortion care. As the use of teleabortion continues to rise, anti-abortion politics, rhetoric, and legislation will continue to press for abortion restriction in the US. If the focus of abortion care shifts solely to teleabortion, the future of comprehensive in-clinic abortion care could be further eroded. Moreover, if women were to lose the right to an abortion, then the legal standing of abortion would be left to the states who have historically adopted abortion-related laws, many of which have been unjust and restrictive of women's rights ("States with Gestational Limits for Abortion"; "An Overview of Abortion Laws").

Importantly, teleabortion is also limited by a strict time cut-off. Medication abortion can only be prescribed up to 70 days of gestation, and teleabortion is only available to women who are no more than nine weeks pregnant. Women seeking an abortion who are more than nine weeks pregnant may be forced to explore other avenues to achieve an abortion; if in-clinic, comprehensive care is eroded, these other means could be unsafe or illegal. Furthermore, if these women lack access to in-clinic abortion care, then we could also be subjecting them to an increased risk of emotional, physical, or social harm. Lastly, we cannot overlook the fact that not all women may choose to have a medication abortion if given the option. When considering these circumstances, it is possible that restricting teleabortion may serve as a strategy for maintaining in-clinic abortion service usage and preventing additional abortion clinic closures.

In short, abortion care is under considerable political and social threat. Teleabortion has been advocated in the US as a possible solution to growing threats on abortion rights. Although telemedicine is not a new platform, its use to provide medication abortion services (teleabortion) is a relatively new service for women in the US. As such, it necessitates careful evaluation. As detailed above, one major reason in support of the promotion of teleabortion is the expansion of abortion access it provides in a time where an increasing number of abortion clinics are being shut down. In many ways teleabortion solves the problem of access to abortion, while also promoting several other factors that are significant to abortion care, such as privacy. That said, because of the novelty of this technological application, we should be careful to consider and evaluate the potential risks to this service platform.

3 Looking Forward

Many of the arguments that have previously been put forth regarding telemedicine can lend a richer analysis to discussion of teleabortion. Teleabortion is relatively novel and little ethical work has been done in this space. However, teleabortion can be categorized into the broader platform of telemedicine, which has a robust field of literature and an accepted ethical framework used to evaluate challenges and morally relevant issues. The benefit of the relationship between the two is that current and prospective implications of teleabortion can be borrowed from the telemedicine literature.

As I've alluded to above, there are numerous reasons why we ought to promote teleabortion, including some reasons that may not seem obvious or necessary, such as cost-effectiveness or

privacy promotion. Conversely, I have also articulated some reasons why we ought to be concerned about teleabortion, and why teleabortion may necessitate careful precautions to ensure that it is adopted and implemented in a way that solely stands to benefit women rather than worsen the barriers they face when trying to receive comprehensive reproductive care. The purpose of this thesis is to explore the ethical issues raised by the prospect of implementing teleabortion, investigate the legitimacy of these concerns, and highlight the cautionary aspects of teleabortion that we ought to consider and subsequently, attempt to mitigate. While the overall claim of this thesis is one in support of teleabortion, technologies such as this one require stakeholders to consider the potential consequences of the adoption and promotion of teleabortion in the US and proceed with caution.

3.1 Evaluating the Moral Considerations

None of the morally relevant considerations that I have raised regarding teleabortion seem to undermine the basic claim that teleabortion ought to be promoted as an abortion option for women. At its core, teleabortion was developed in response to issues of justice. Teleabortion is capable of offering more equitable access to abortion care for women across the US. Additional benefits such as enhanced privacy, cost-effectiveness, and greater access, as described, can enable women to choose the medium in which to pursue their abortion care. This platform can be employed to promote women's reproductive choices, and help all women achieve better access to healthcare and exercise the right to an abortion.

However, these considerations *do* raise morally relevant concerns regarding the ways in which teleabortion could affect future abortion care. Not only could teleabortion change the primary way

we provide abortion care in the US, its widespread adoption could have larger consequences for non-teleabortion services sought out by women. It is impossible to predict what abortion care will look like in the next few years or decades, but the most salient concern raised in this thesis is how teleabortion may effect current abortion clinics and in-clinic abortion care. Widespread adoption of teleabortion could jeopardize the usage of abortion clinics and alter the way the general public views abortion. Women who cannot utilize teleabortion may be penalized or harmed if teleabortion becomes the norm for abortion care.

Although teleabortion clearly offers great advantages to women in need of abortion care, the full advantages of teleabortion cannot be experienced if we do not minimize the drawbacks that this platform may have. In order to best mitigate the concerns that teleabortion raises we ought to promote *all* forms of abortion care, including teleabortion while simultaneously promoting women and their right to comprehensive reproductive healthcare.

3.2 Is Teleabortion a Concession to Injustice?

As discussed above, telemedicine has largely been a reaction to growing disparities in healthcare access and availability. While telemedicine represents a 21st century 'fix' to a decades old problem, it illustrates the ways in which our healthcare system is broken and unjust. In particular, the growing need for teleabortion across the US demonstrate these injustices even more clearly. Despite the advantages of teleabortion, which may be a better form of abortion care for many women, the need for teleabortion has grown out of the continued restrictions in access to abortion care in the US and our societal failure to promote women's health and reproductive rights in the face of heightened anti-abortion movements. While teleabortion fills a growing need in the US,

this need may not have manifested, had we refused to ignore the obvious flaws in our healthcare system and allow abortion access to be increasingly restricted at the state-level.

While teleabortion meets a significant need for many women across the country who may encounter barriers to abortion care, we should not concede to an unjust healthcare system that fulfills women's abortion services through remote care and in-home management. Rather than enriching a woman's reproductive choices, teleabortion simplifies women's abortion care into a service that can be offered through virtual communication and privatized procedures, equating it with a common cold or rash. By categorizing both abortion care and women's health in this way, we make a concession to the injustices in the healthcare system that have historically push women into the margins of medical care and rendered their health as one requiring restrictions. Although teleabortion offers a rational solution to a growing problem, the fact that this problem was allowed to persist is the true root of the problem. Teleabortion may inadvertently limit the options women have to make informed decisions about their health, and receive safe, reliable, comprehensive healthcare.

Ideally, women should be able to receive the basic healthcare they need, but current trends in abortion access and legislation indicate that this might not be the case. Laws such as the Texas law that would make abortion a punishable offense deserving of the death penalty (Stanley-Becker), or the new 'heartbeat' abortion ban signed into law in Ohio, which would ban receipt of an abortion after the detection of a heartbeat, a development which typically occurs around the same time most women find out they are pregnant (Chokshi) highlight the injustices women face in exercising their right to abortion and reproductive autonomy, and the need to address the issues in women's health.

While it is a moral cost to concede to any injustice, especially one that affects half of the population, what we also fail to recognize in the debate about teleabortion is the subgroup of women who will, for whatever reason, be unable to meet the necessary requirements for a teleabortion. Women will still require in-clinic abortions and it is imperative that we protect the options those women have to obtain abortions in the US. Given the unpredictable future of abortion access in the US, it seems that we have little choice but to promote teleabortion services for the access it provides during the abortion crisis we are experiencing. Teleabortion has filled a gap in reproductive care for women, but it also highlights the societal need to promote women's health at all times. Women have a right to unrestricted, comprehensive reproductive healthcare and we must recognize the ways in which teleabortion may promote or hinder that right. Teleabortion represents a way to promote women's rights to an abortion, but the provision of teleabortion does not mean that we get to convince ourselves that it solves our abortion crisis. What teleabortion really represents is our acceptance of an injustice in the healthcare system, offering only a bandaid to a deeper wound.

4 Concluding Thoughts

Abortion care in the US is a highly complex and morally-loaded topic, which requires thoughtful consideration from many stakeholders. As in-clinic abortion care in the US becomes more disparate, teleabortion will likely continue to rise in popularity and use. Teleabortion can offer a substantial number of benefits to women seeking an abortion, but there are legitimate concerns about the consequences of teleabortion and what it could mean for future abortion care. Rather than serving as a solution to a growing disparity of abortion care in the US, teleabortion should

instead be offered as an additional option for women seeking abortion care. Teleabortion should not be credited as the solution to abortion disparities in the US, but rather as another service through which women can freely access and receive an abortion.

To achieve this goal, I recommend that we implement some potential strategies that can help aid in promoting women's health and avoid the potential adverse consequences incurred by teleabortion. If we acknowledge the state of abortion affairs in the US and the ways in which teleabortion has become a growing service, we ought to promote any service that advances women's access to abortion and women's exercise of their reproductive rights. To accomplish this, it is essential that we lift the current REMS restrictions on mifepristone (Herrera; "Approved Risk Evaluation and Mitigation Strategies (Rems)"; "Mifeprex (Mifepristone) Information"; "Medication Abortion" (Kaiser Family Foundation)). REMS restrictions limit the delivery of one of the main medications necessary to initiate a medication abortion. Lifting these restrictions would permit the legal delivery of mifepristone by mail, and would free up providers who are required to administer the drug. Providers should also be made aware of teleabortion services, and be provided with the tools needed to implement said services to women all across the country. Teleabortion will likely reduce the demands placed on providers, especially for patients who meet the requirements for a self-induced, medication abortion. In addition, providers of abortion care can reach a larger population of women, who may necessitate or desire an abortion, but may not have the means necessary to travel to an abortion clinic within her state. Teleabortion could also be a useful service for existing abortion clinics, which may have increasing strains to serve larger populations as the number of abortion clinics shrink. Abortion

clinic closures and abortion needs are not decreasing at a matching rate, thus, teleabortion could be a way for existing clinics to remotely reach more women at the required rate.

Teleabortion has the potential to become an integral part of the comprehensive care offered by abortion clinics, and may provide another option for women seeking an abortion to choose from. Subsequently, this adoption and expansion requires advocacy for a teleabortion option in abortion clinics, hospitals, and private practices. Lastly, and most importantly, the promotion of teleabortion also demands the staunch support for the expansion of women's rights to choose. Women retain the right to an abortion, yet this right has been increasingly undermined by divisive political agendas and anti-feminine health priorities. Teleabortion and broader abortion promotion may break ground in the conversation on abortion and highlight its importance for women in the US and our society.

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